

Oakland County

Employee Benefits Unit Use Only
 Act/Rsn _____ Mbr Chg _____
 DPDT _____ DE _____

Membership and Record Change Form

Check applicable box:

<input type="checkbox"/> Active Employee	<input type="checkbox"/> Blue Preferred Plan (PPO)	<input type="checkbox"/> Comprehensive Major Medical (CMM)	<input type="checkbox"/> Blue Cross/BlueShield Vision
<input type="checkbox"/> Retiree	<input type="checkbox"/> Blue Choice (POS)	<input type="checkbox"/> Health Alliance Plan (HAP)	<input type="checkbox"/> DeltaUSA Dental
<input type="checkbox"/> Blue Cross/Blue Shield			

PERSONAL INFORMATION:

Your name as it appears on your social security card: _____ / /

Subscriber's Last Name Subscriber's First Name M.I. Date of Birth

SSN EMPLOYEE ID# Telephone: Home / Work

Check here if new address

Home Address Street City State Zip

REQUEST FOR MEMBERSHIP CHANGE

ADD Members to contract (additions)

Event	Name (last, first)	Event Date	Date of Birth	SSN (Required)	Sex	HAP Physician Code
<input type="checkbox"/> Marriage to						
<input type="checkbox"/> Birth of Child						
<input type="checkbox"/> Stepchild						
<input type="checkbox"/> Child by legal adoption						
<input type="checkbox"/> Child by legal guardianship						
<input type="checkbox"/> Principal support of child						
<input type="checkbox"/> Sponsored Dependent						
<input type="checkbox"/> Other						

For any child named above, is there a court order saying which parent is responsible for providing health insurance? **If yes, attach a copy of the court order.**

Yes If "YES", which parent? Father
 No Mother

REMOVE members from contract (deletions). Please fill out "Supplemental Form" for COBRA.

Event	Name (last, first)	Event Date	Date of Birth	SSN (Required)	Sex
<input type="checkbox"/> Divorce from					
<input type="checkbox"/> Death of Dependent					
<input type="checkbox"/> Dependent/ Misc					
<input type="checkbox"/> Other					

REQUEST FOR RECORD CHANGE

CHANGE OF NAME: Last First MI

ADDITIONAL INFORMATION:

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT TO MY KNOWLEDGE AND BELIEF.

Subscriber's Signature _____ Date _____

EMPLOYEE BENEFITS USE ONLY

Group Authorization Signature _____ Effective Date _____ Group/Suffix: _____

INSTRUCTIONS

THIS FORM SHOULD BE COMPLETED TO REPORT ALL MEMBERSHIP AND RECORD CHANGES TO THE EMPLOYEE BENEFITS UNIT. THIS FORM MUST BE SIGNED AND DATED WITHIN 30 DAYS OF THE EVENT.

REQUEST FOR MEMBERSHIP CHANGE

ADD MEMBERS TO CONTRACT:

MARRIAGE	YOU MAY COMPLETE THIS FORM UP TO 30 DAYS BEFORE OR 30 DAYS AFTER THE MARRIAGE. COVERAGE WILL BE EFFECTIVE AS OF THE DATE OF THE MARRIAGE.
BIRTH OF CHILD	REPORT WITHIN 30 DAYS OF THE BIRTH DATE.
STEPCHILD	YOU MAY COMPLETE THIS FORM UP TO 30 DAYS BEFORE OR 30 DAYS AFTER THE MARRIAGE. CHILDREN MUST RESIDE WITH YOU AND BE CLAIMED AS DEPENDENTS.
CHILD BY LEGAL ADOPTION	REPORT WITHIN 30 DAYS OF THE DATE OF PETITION OR DATE CHILD TAKES UP RESIDENCE, WHICHEVER IS LATER.
CHILD BY LEGAL GUARDIANSHIP/WARD	SAME AS LEGAL ADOPTION.
PRINCIPAL SUPPORT OF CHILD	DO NOT CONFUSE WITH THE SUPPORT OF STEPCHILDREN. THIS CATEGORY INCLUDES DEPENDENTS SUCH AS GRANDDAUGHTER, NEPHEW, ETC. GIVE THE DATE SUPPORT BEGAN. UNLESS OTHERWISE SPECIFIED, THE CHILD'S EFFECTIVE DATE WILL BE NO EARLIER THAN 90 DAYS AFTER SUPPORT FOR 6 MONTHS HAS BEEN ESTABLISHED.
OTHER	USE THIS AREA FOR REQUESTING THE ADDITION OF ANY OTHER ELIGIBLE DEPENDENT NOT LISTED ABOVE THEN COMPLETE THE "ADDITIONAL INFORMATION" SECTION DESCRIBED BELOW AND INCLUDE SUPPORTING DOCUMENTATION.
SPONSORED DEPENDENT	YOU MAY COMPLETE THIS FORM UP TO 30 DAYS BEFORE THE EFFECTIVE DATE.

REMOVE MEMBERS FROM CONTRACT:

DEATH OF DEPENDENT	GIVE THE NAME OF THE DECEASED DEPENDENT AND DATE OF DEATH.
DIVORCE FROM	GIVE THE NAME OF THE DIVORCED SPOUSE AND DATE OF DIVORCE. UNDER "ADDITIONAL INFORMATION" INDICATE IF COVERAGE FOR THE CHILD(REN) IS TO BE CONTINUED ON THE SUBSCRIBER'S CONTRACT OR ON A CONTRACT ISSUED TO THE DIVORCED SPOUSE. BE SURE TO INCLUDE THE SOCIAL SECURITY NUMBER AND ADDRESS OF THE DIVORCED SPOUSE ON THE "SUPPLEMENTAL" FORM.
DEPENDENT/MISC	USE THIS FOR DEPENDENTS WHO GET MARRIED, OBTAIN OTHER COVERAGE, NO LONGER MEET ELIGIBILITY REQUIREMENTS, ETC. PLEASE COMPLETE "SUPPLEMENTAL" FORM.
OTHER	USE THIS AREA FOR REQUESTING THE DELETION OF ANY OTHER DEPENDENT NOT COVERED ABOVE THEN COMPLETE THE "ADDITIONAL INFORMATION" SECTION DESCRIBED BELOW.

REQUEST FOR RECORD CHANGE

CHANGE OF NAME	ENTER THE NEW NAME, THE FORMER NAME SHOULD BE ENTERED ON THE TOP LINE OF THE FORM.
ADDITIONAL INFORMATION	USE THIS SPACE TO INCLUDE THE NAMES, ADDRESSES, SOCIAL SECURITY NUMBERS AND OTHER INFORMATION SPECIFICALLY REQUESTED UNDER OTHER AREAS OF THIS SECTION.